House of Representatives

General Assembly

File No. 315

February Session, 2012

Substitute House Bill No. 5450

House of Representatives, April 10, 2012

The Committee on Human Services reported through REP. TERCYAK of the 26th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT ESTABLISHING A BASIC HEALTH PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) (a) Not later than January 1, 2014, the Commissioner of Social Services, in consultation with the Office of Health Reform and Innovation, shall establish and implement a basic health program in accordance with Section 1331 of the federal Affordable Care Act. On and after January 1, 2014, all individuals under sixty-five years of age with income not exceeding two hundred per cent of the federal poverty level, and who are ineligible for medical assistance pursuant to Title XIX of the Social Security Act, and otherwise eligible for medical assistance under Section 1331 of the Affordable Care Act, shall be eligible for medical assistance under a basic health program. For purposes of this section and section 6 of this act, "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, as both may be amended from time to time, and any regulations adopted under said acts.

(b) Medical assistance provided through the basic health program shall include the benefits, limits on cost-sharing and other consumer safeguards that apply to medical assistance provided in accordance with Title XIX of the Social Security Act, unless the commissioner determines that the cost of medical assistance provided to enrollees in the basic health program will exceed the federal subsidies available to the state to fund the program. If the commissioner so determines, the commissioner, in consultation with the Office of Health Reform and Innovation, shall develop and submit a plan, in accordance with section 2 of this act, for the basic health program that maximizes benefits and minimizes cost-sharing, within funds available from federal subsidies to fund the program.

(c) Individuals enrolled in the basic health program shall include adults with incomes exceeding one hundred thirty-three per cent of the federal poverty level, but not exceeding two hundred per cent of the federal poverty level, who would otherwise be eligible for HUSKY Plan, Part A benefits.

(d) To the extent that federal funds received for the basic health program exceed the cost of medical assistance that would otherwise be provided to program enrollees pursuant to Title XIX of the Social Security Act, the commissioner, to the extent permitted under federal law, shall use the excess of such federal funds to increase reimbursement rates for providers serving enrollees receiving benefits pursuant to the basic health program. The commissioner shall increase reimbursement rates in a manner that will maximize access to needed health services. The commissioner shall establish a committee charged with making recommendations to (1) keep provider rates competitive, (2) provide payment incentives that increase access to primary care offices as an alternative to emergency room care, and (3) streamline paperwork. The committee shall be comprised of representatives of the Department of Social Services and providers who participate in the basic health program and Medicaid.

(e) The Commissioner of Social Services shall take all necessary

actions to maximize federal funding and seek any necessary approvals from the federal government in connection with the establishment of a basic health program.

Sec. 2. (*Effective from passage*) (a) Not later than October 1, 2012, the Commissioner of Social Services, in consultation with the Office of Health Reform and Innovation, shall submit a plan, and any federal waiver application required, for the establishment and implementation of a basic health program to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies.

(b) Not later than thirty days after the date of their receipt of such plan, the joint standing committees shall hold a public hearing. At the conclusion of a public hearing held in accordance with the provisions of this section, the joint standing committees shall advise the commissioner of their approval, denial or modifications, if any, of the plan and any federal waiver required.

(c) If the joint standing committees do not concur, the committee chairpersons shall appoint a committee of conference which shall be composed of three members from each joint standing committee specified in subsection (a) of this section. At least one member appointed from each joint standing committee shall be a member of the minority party. The report of the committee of conference shall be made to each joint standing committee specified in subsection (a) of this section, which shall vote to accept or reject the report. The report of the committee of conference may not be amended. If a joint standing committee rejects the report of the committee of conference, such joint standing committee shall notify the commissioner of the rejection and the commissioner's plan shall be deemed approved. If the joint standing committees accept the report, the committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the commissioner of their approval, denial or modifications, if any, of the commissioner's plan. If the joint standing committees do not so advise the commissioner during the

thirty-day period, the plan shall be deemed approved. Any plan or necessary waiver submitted to the federal government pursuant to this section shall be in accordance with the approval or modifications, if any, of the joint standing committees of the General Assembly having cognizance of matters relating to human services, appropriations and the budgets of state agencies.

Sec. 3. Subsection (a) of section 17b-261 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (e) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917(c) of the Social Security Act, 42 USC 1396p(c), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a family unit of equal size with no income under the temporary family assistance program in the appropriate region of

residence. Except as provided in section 17b-277, the medical assistance program shall provide coverage to persons under [the age of] nineteen years of age with family income up to one hundred eighty-five per cent of the federal poverty level without an asset limit and to persons under [the age of] nineteen years of age and their parents and needy caretaker relatives, who qualify for coverage under Section 1931 of the Social Security Act, with family income up to one hundred eighty-five per cent of the federal poverty level without an asset limit. On and after January 1, 2014, and contingent upon the implementation of a basic health program with the same benefits, limits on cost sharing and other consumer safeguards provided under Title XIX of the Social Security Act, coverage shall be provided to parents and needy caretaker relatives of persons under nineteen years of age, who qualify for coverage under Section 1931 of the Social Security Act, with family income up to one hundred thirty-three per cent of the federal poverty level without an asset limit. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of (1) the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance, (2) the effect that having income that exceeds the limits prescribed in this subsection will have with respect to program eligibility, and (3) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17b-751b. Persons who are determined ineligible for assistance pursuant to this section shall be provided a written statement notifying such persons of their ineligibility and advising such persons of the availability of HUSKY Plan, Part B health insurance benefits.

Sec. 4. Subsection (a) of section 17a-22h of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall develop and implement an integrated behavioral health service system for HUSKY Plan Parts A and B members and children enrolled in the voluntary services program operated by the Department of Children and Families and may, at the discretion of the commissioners, include: (1) Other children, adolescents and families served by the Department of Children and Families or the Court Support Services Division of the Judicial Branch; (2) Medicaid recipients who are not enrolled in HUSKY Plan Part A; **[**and**]** (3) Charter Oak Health Plan members; and (4) on and after January 1, 2014, enrollees in the basic health program. The integrated behavioral health service system shall be known as the Behavioral Health Partnership. The Behavioral Health Partnership shall seek to increase access to quality behavioral health services by: (A) Expanding individualized, family-centered and community-based services; (B) maximizing federal revenue to fund behavioral health services; (C) reducing unnecessary use of institutional and residential services for children and adults; (D) capturing and investing enhanced federal revenue and savings derived from reduced residential services and increased community-based services for HUSKY Plan Parts A and B recipients; (E) improving administrative oversight and efficiencies; and (F) monitoring individual outcomes and provider performance, taking into consideration the acuity of the patients served by each provider, and overall program performance.

Sec. 5. (*Effective from passage*) (a) For the fiscal years ending June 30, 2014, and June 30, 2015, the sum of thirty-six million dollars, reflecting fifty per cent of any projected savings from reducing HUSKY Plan, Part A adult coverage from those with family incomes up to one hundred eighty-five per cent of the federal poverty level to those with family incomes up to one hundred thirty-three per cent of the federal poverty level, is appropriated to the Department of Social Services for the state basic health program.

(b) Funds appropriated to the Department of Social Services under this section shall be used (1) to provide the same benefits and limits on cost-sharing in the state basic health program as apply to medical assistance provided in accordance with Title XIX of the Social Security Act, and (2) to increase reimbursement rates for providers serving individuals receiving benefits pursuant to the basic health program. Reimbursement rates shall be increased pursuant to this section in a manner that will maximize individuals' access to needed health care services.

Sec. 6. (NEW) (*Effective from passage*) There is established an account to be known as the "basic health program account", which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Department of Social Services for the purposes of operating a basic health plan in conformance with Section 1331 of the Affordable Care Act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	17b-261(a)
Sec. 4	*from passage*	17a-22h(a)
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	New section

Statement of Legislative Commissioners:
In section 2(c) references to each committee were clarified and in section 4(a) "recipients of" was changed to "enrollees in" for internal consistency.

HS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Department of Social Services	GF - See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

Overview

The bill requires the Department of Social Services (DSS) to establish, by January 1, 2014, a basic health program (BHP) for adults with incomes from 133% of the federal poverty level (FPL) to 200% FPL[1]. The cost of this program is to be limited to the federal subsidies available under the Patient Protection and Affordable Care Act (PPACA). The bill results in the impact described below based on the following factors: 1) annualized health and administrative costs of BHP enrollees, 2) HUSKY A population, and 3) federal premium and cost sharing subsidies.

In summary, the annualized health and administrative cost, assuming the total eligible population enrolls in the BHP, is estimated between $497.3 million and $825.4 million (as detailed below). The bill requires the program to be operated within available federal subsidies. It is unknown at this time what the value of the federal subsidies will be to offset these costs. Should the subsidies not cover the full cost of the BHP, the bill requires DSS to reduce the BHP plan cost so as to remain within the available federal subsidy. Any such action would likely include a combination of reduced provider rates, reductions to

[1] In 2012, 133% FPL – 200% FPL is $14,856 to 22,340 for a single person.

benefits, or increased premiums and/or cost sharing for enrollees. The bill requires that any BHP plan modifications must be approved by the General Assembly. Should the federal subsidies exceed the costs of the BHP plan, the bill requires DSS to use these funds to increase the provider rates under the program.

Should current BHP eligible enrollees of the HUSKY A program transition to the BHP, the state would realize annualized savings of $72.85 million. For the fiscal years of FY 14 and FY 15, the bill appropriates $36 million of these savings for the state basic health program. The bill also creates a non-lapsing basic health program account. As discussed below, the bill imposes certain restrictions for the HUSKY A population which will impact the ability of the state to achieve savings from this population depending on the structure of the BHP and any actions taken by the agency to keep costs even with federal subsidies.

Federal Subsidies

Under PPACA, the state will receive a federal subsidy for those residents enrolled in the BHP. For FY 14, this subsidy is equal to 95% of what the federal government would have spent on premium tax credits and cost sharing reductions that BHP enrolled individuals would have been eligible for had they purchased private insurance through the State Insurance Exchange[2]. The tax credits and cost sharing reductions are based on the "Silver Plan" on the insurance exchange.

At this time, the federal government has not determined what the final essential benefit package will be, which will dictate both the cost of the Silver Plan and the value of the associated federal subsidy. From January 1, 2014 until January 1, 2016, the federal government has given the state responsibility to determine the essential benefit package

[2] The federal government has the option of changing the percentage of this subsidy in subsequent years.

(EHB)[3]. Until the state chooses an EHB, the aggregate amount of the per person subsidy available to offset the BHP program costs is not known. It is uncertain what the impact will be to subsidies when the federal government reevaluates the EHB in 2016.

In addition, the mechanism for distributing the subsidy to the states has not been established. To the extent that costs are incurred before receipt of the subsidy, these costs may be the initial responsibility of the state.

Population Estimate

The bill specifies that all adults under the age of 65 with incomes between 133% FPL and 200% FPL are eligible for the BHP. The BHP may also include parents of children currently enrolled in the HUSKY A program who's incomes fall within this range (please see section on HUSKY A adults below).

Assuming that the HUSKY A parents are enrolled in the BHP, the program is expected to have 103,100 eligible enrollees in total[4]. Should the HUSKY A parents not enroll due to any benefit adjustments or cost sharing, the eligible population would be 72,100.

Health Cost Estimate

The BHP is required to have the same benefits and cost sharing as the Medicaid program (unless federal subsidies do not cover the cost

[3] The state may choose between one of the three largest state employee health plans (by enrollment); one of the three largest federal employee health plan options; the largest HMO plan offered in the state or one of the three largest small-group plans in the state.

[4] This assumes 31,000 former HUSKY A parents and 72,100 non-HUSKY adults. According to Connecticut Department of Revenue Services data, there were approximately 202,000 tax filers with incomes between $14,856 and $21,660 in 2010. The U.S. Census Bureau estimates that 29% of individuals with incomes under $25,000 are uninsured. This would yield approximately 58,600 individuals. It is further assumed that 13,500 of those in this income bracket who currently have insurance would likely transition to BHP, for a total of 72,100 non-HUSKY BHP potential enrollees.

of the program, discussed below). It is likely that should the approximately 31,000 eligible HUSKY A adults transfer to the BHP, their costs would be relatively similar in both programs. Based on DSS cost data for this group, it is estimated that they would represent a FY 14 cost of $145.7 million[5].

The cost profile of the non-HUSKY A BHP enrollees is not known[6]. However, it is likely to include certain individuals with significantly higher cost profiles than the relatively young HUSKY A adults[7]. The table below illustrates three potential cost scenarios in addition to the HUSKY A adults discussed above. First, if the non-HUSKY A adult population (72,100) has a cost profile equal to that of HUSKY A adults, there would be a FY 14 cost of $4,700 per person. Second, if the population has a cost profile approximately 20% above the HUSKY A population, there would be a FY 14 cost of $5,640 per person. Third, should the cost reflect the recent experience with the Medicaid Low Income Adult (LIA) population, there would be a FY 14 cost of $9,250[8] per person. Based on these cost and the caseload assumptions, the range of costs to enroll all eligible individuals would be as follows:

	HUSKY A	**Non-HUSKY A**		
	HUSKY A BHP	Scenario 1	Scenario 2	Scenario 3
Cost per Case ($)	4,700	4,700	5,640	9,250
Estimated Number Cases	31,000	72,100	72,100	72,100
Total Cost	145,700,000	338,870,000	406,644,000	666,925,000
Combined BHP Cost		**484,570,000**	**552,344,000**	**812,625,000**

[5] Based on DSS health cost data, inflated at 5% annually, there is a per person cost of $4,700. (Source: An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act, CBO, November 30, 2009).

[6] Although numerous studies have produced comparative per person cost estimates for this population, the following estimates are based on actual Connecticut Medicaid expenditures in order to properly reflect the Connecticut benefit package and rate structure.

[7] A portion of high cost Medicaid clients who currently use their own resources to spend down to Medicaid eligibility may instead be able to enroll in the BHP. There is also likely to be a pent up demand for services among previously uninsured and underinsured enrollees.

[8] Current annual LIA cost of $8,400, inflated by 5% per year until FY 14.

Even with the individual mandate included in PPACA, it is unlikely that 100% of the eligible individuals would enroll in the BHP. Therefore, the cost range noted above would be proportionately lower based on whatever enrollment rate is achieved.

Administrative Cost Estimate

The cost figures noted above are based on fee-for-service claims data from DSS. The department would also realize significant administrative costs related to a BHP expansion. DSS has recently moved Medicaid recipients into a non-risk administrative service organization (ASO) system. Based on the Governor's recommended FY 13 budget adjustments, there is a per member, per month administrative cost of $10.30 under the ASO. This would result in an annualized administrative cost of up to $12.74 million for the BHP.

HUSKY A State Savings

The bill requires current HUSKY A adult enrollees with incomes between 133% and 185% FPL to move to the new BHP, if the BHP has the same benefits, limits on cost sharing and other consumer safeguards as the Medicaid program. Under the Medicaid program, the state and federal government currently equally split the cost of these HUSKY A clients. Therefore, by moving these clients to a BHP that is to be fully supported by federal subsidies, the state would save approximately $72.85 million annually. Should the HUSKY A clients not move to the BHP due to any BHP benefits, limits on cost sharing and other consumer safeguards that are not the equal of Medicaid, the state would not realize these savings.

Section 5 of the bill appropriates to DSS $36 million from this potential savings in both FY 14 and FY 15. DSS is to use these funds to 1) equalize benefits and limits on cost sharing under BHP to that of the Medicaid program, and 2) to increase provider reimbursement rates.

The Out Years

The bill requires the Basic Health Program to be established and

implemented by January 1, 2014, resulting in the impact described above. Although the bill specifies that the cost of the BHP is limited to the federal subsidies available under PPACA, such subsidies are subject to change when the federal government reevaluates the essential benefit package after 2016.

OLR Bill Analysis
sHB 5450

AN ACT ESTABLISHING A BASIC HEALTH PROGRAM.

SUMMARY:

This bill requires the Department of Social Services (DSS) commissioner, in consultation with the Office of Health Reform and Innovation (OHRI), by January 1, 2014, to establish and implement a Basic Health Program (BHP) in accordance with the federal Patient Protection and Affordable Care Act (PPACA) of 2010. Under the program, the state would provide federally subsidized health insurance to individuals (1) with incomes up to 200% of the federal poverty level (FPL), (2) under age 65, and (3) who do not qualify for Medicaid and otherwise meet the federal eligibility criteria. (Starting January 1, 2014, federal law requires state Medicaid programs to cover anyone with income up to 133% of the FPL.) Individuals in the BHP would not be able to get their health insurance through the state's health insurance exchanges, which the state must establish by 2014 (see BACKGROUND).

The bill requires the BHP to offer the same benefit levels and limited cost sharing (e.g., co-pays) that the state's Medicaid recipients currently enjoy unless the state's cost exceeds the federal subsidies. The bill moves certain HUSKY A (a Medicaid coverage group) adult recipients into the BHP provided that they maintain the same level of benefits and cost sharing limits (currently they do not pay cost sharing). The bill appropriates to DSS the anticipated savings from moving HUSKY A adults into the BHP in order to (1) provide the same benefits and cost sharing to BHP enrollees that apply to Medicaid recipients and (2) increase provider reimbursement rates.

The bill requires the DSS commissioner, in consultation with OHRI,

to submit a BHP implementation plan to the Human Services and Appropriations committees for their approval.

The bill requires DSS to take all necessary steps to maximize federal funding and seek any necessary federal approval in connection with establishing the BHP. And it establishes a separate, nonlapsing General Fund account to hold the federal subsidies.

EFFECTIVE DATE: Upon passage

BASIC HEALTH PROGRAM (BHP)

The bill requires the establishment of a program resembling the state's Medicaid program. But this can happen only if the state receives sufficient federal subsidies. Consequently, it creates contingencies in the event these subsidies are not enough to cover the costs of insuring program enrollees.

Program Benefits and Cost Sharing

Under the bill, the medical assistance provided through the BHP must include the same benefits, cost-sharing limits, and other consumer safeguards that apply to Medicaid recipients, unless the DSS commissioner determines that doing so will exceed the federal subsidies available to the state to pay for the BHP.

If the commissioner makes such a determination, he, in consultation with OHRI, must develop and submit a plan that maximizes benefits and minimizes cost sharing to run the program within the available subsidies.

People Covered by BHP (§§ 1(c) & 3)

Under the bill, adults with incomes between 133% and 200% of the FPL who would "otherwise be eligible for HUSKY A" are explicitly mentioned as being covered by the BHP (Under federal law, anyone ineligible for other health insurance coverage with income in this range is eligible for the BHP.) Currently, an adult is eligible for HUSKY A if he or she is the caretaker relative of a child receiving HUSKY A and has income up to 185% of the FPL.

The bill shifts HUSKY A- eligible adults to BHP once their income reaches 133% of the FPL, but only if the state implements a BHP that offers the same benefits, cost sharing limits, and other consumer safeguards that currently apply under HUSKY A.

Because the bill contemplates that the BHP may have to impose cost sharing and benefit limits if the federal subsidies are insufficient, there could be two different outcomes. If the federal subsidies are sufficient to hold the HUSKY A caretaker adults harmless, these adults would be moved into the BHP, and the state could potentially realize a cost savings (the state receives a 50% federal match for HUSKY A expenditures). If the subsidies are not sufficient, these caretaker adults would stay in HUSKY A and any limits on cost sharing and benefit levels would apply only to (1) childless adults with incomes between 133% and 200% of the FPL and (2) adult caretaker relatives of children with income between 185% and 200% of the FPL, who would comprise the BHP enrollees.

Appropriation of Savings from Moving HUSKY A Adults into BHP (§ 5)

It is anticipated that the state would save $36 million over the next two fiscal years by moving HUSKY A adult caretakers to BHP. If these savings occur, the bill appropriates the savings to DSS for the BHP.

DSS must use these funds to (1) provide the same benefits and limits on cost-sharing in the BHP that apply to Medicaid recipients and (2) increase reimbursement rates to medical providers serving BHP enrollees. DSS must increase the reimbursement rates to maximize health care access.

The $36 million appropriation is contingent on whether moving HUSKY A adult caretaker relatives provides the savings.

Use of Surplus Subsidies (§ 1(d))

As with the above appropriation, if the federal premium subsidies the state receives for the BHP exceed the costs of providing the Medicaid-equivalent coverage to BHP enrollees, the surplus must be

used to increase reimbursement rates for providers serving BHP enrollees, to the extent federal law allows. The commissioner must increase the rates in a way that maximizes access to needed health services.

The bill requires the commissioner to establish a committee to make recommendations to (1) keep provider rates competitive, (2) provide payment incentives to increase access to primary care offices as an alternative to emergency room care, and (3) streamline paperwork. The committee is comprised of representatives from DSS and health care providers serving Medicaid and BHP enrollees.

DSS Plan (§ 2)

The bill requires the DSS commissioner, in consultation with the OHRI, to submit to the Human Services and Appropriations committees a plan and any federal waiver application that might be necessary to establish and implement the BHP to the Human Services and Appropriations committees.

The committees must hold a hearing on the plan within 30 days of receiving it. They must advise the commissioner of the approval, denial, or modification of the plan or waiver request at the hearing's close.

If the committees do not concur, the bill requires their chairmen to appoint a conference committee composed of three members from each committee. At least one member from each committee must be from the minority party.

The conference committee must report to each standing committee, which must vote to accept or reject the report. The report cannot be amended.

If either committee rejects the conference report, it must notify the commissioner and the plan is deemed approved. If the committees accept the report, the Appropriations Committee must advise the DSS commissioner of their decision. If the committees do not advise the

DSS commissioner during the 30-day period, the plan is likewise deemed approved.

Any plan or necessary waiver DSS submits to the federal government must be in accordance with the committees' actions.

Integration with Behavioral Health Partnership (§ 4)

The bill requires that BHP recipients be part of the Behavioral Health Partnership starting January 1, 2014.

Basic Health Program Account (§ 6)

The bill establishes a BPH account as a separate, non-lapsing account in the General Fund to hold any monies required by law to be deposited into it. DSS must use money in the account to operate the BHP, in accordance with federal law.

BACKGROUND

BHP—Federal Law

Section 1331 of PL 111-148 allows states, beginning in 2014, to establish BHPs for individuals (1) ineligible for Medicaid, (2) under age 65, (3) who have household income between 133% and 200% of the FPL (individuals with incomes under 133% of the FPL will qualify for Medicaid), and (4) are ineligible for minimal essential health care coverage (e.g., State Children's Health Insurance Program (HUSKY B in Connecticut) or cannot afford their employer's coverage. Legal aliens living in the U.S. for less than five years and who have incomes up to 133% of the FPL are also eligible.

The federal law imposes limits on cost sharing, and requires that state BHPs provide benefits at least as generous in the state's Essential Health Benefits package as would be available to someone getting their insurance from the state's health insurance exchange.

States that operate BHPs are eligible for federal subsidies equaling 95% of the premium tax credits and cost sharing reductions that the federal government would have spent if BHP enrollees had received this assistance when enrolling in a health insurance exchange plan.

The law requires states to establish funds (trusts) into which the federal subsidies are deposited and which can only be used to reduce the premiums and cost sharing of, or provide additional benefit for, people enrolled in a BHP health plan (42 USC § 18051).

Health Insurance Exchange

A health insurance exchange is a set of state-regulated and standardized plans from which individuals may purchase health insurance eligible for federal subsidies. Under the PPACA, all exchanges must be fully certified and operational by January 1, 2014.

Federal Poverty Levels (FPL)

The following are the 2012 FPLs for family sizes of one to three people.

Family Size	*100% of FPL*	*133% of FPL*	*200% of FPL*
1	$11,170	$14,856	$22,340
2	15,130	20,123	30,260
3	19,090	25,390	38,180

Related Bill

SB 425, favorably reported by the Public Health Committee, also establishes a BHP.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 10 Nay 6 (03/22/2012)